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ABSTRACT

The concern with licensure and certification is responsive to the profession's need to insure that individuals entering into the practice of psychology are well grounded in the core body of knowledge appropriate to such practice. Current trends toward exclusivity in licensure and certification, however, will have a disproportionately adverse effect on minority health service providers. Because the proposed regulations would require training in psychology departments, minorities who have been forced by racism and other discriminatory factors to seek comparable training in related disiplines would not qualify for licensure. This would contribute to the forces that already prevent ethnic minority individuals from achieving employment opportunities that would permit them to serve minority populations. Another results would be that indigent populations, comprised mostly of minorities, not serviced by traditional health service providers, will seek these services from others (e.g., medicine men). It would appear that both existing and proposed licensure and certification guidelines are not in the best interest of minority professionals or communities. (Author/EB)

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Implications of Licensure, Certification and Credentialing for Minority Providers

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There is an increasing effort to tighten the codes and regulations that govern the practice of psychology. Traditionally, two approaches have been used in this regard; namely licensure and certification. Licensure is the regulation of the title and practice of psychology, whereas certification refers only to the use of the title. This generic approach to licensure recognizes psychology as a discipline based upon an integrated body of knowledge and practice. As will be seen later in this paper, recent licensure proposals recommend greater specificity as regards the appropriate "body of knowledge and practice."

Historically, certification and licensure grew out of public complaints of unethical practices and a subsequent awareness that the profession could best protect itself against such charges by establishing guidelines and standards, and then monitoring those guidelines and standards. Invariably, the imposition of such controls will produce at least two effects. In general, licensure requirements will produce a set of uniform standards that will tend to have a positive impact on the quality of training and service delivery. On the other hand, any set of standards will tend toward exclusivity rather than inclusivity, thereby restricting the degrees of freedom of some. While both of these outcomes are of importance to our discussion, I suspect the latter will be central to the issues and themes of this conference. Trends toward exclusivity in licensure and certification will have a disproportionately adverse effect on minority health service providers. It is these adverse effects that I will address in this paper. Before doing so, however, we need to take a look at the state of licensure and certification requirements.

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LICENSURE

Most states (presently 37) follow the approach recommended by the 1967 Model for State Legislation Affecting the Practice of Psychology. That is, through licensure laws, an effort is made to prevent unlicensed individuals from engaging in the practice of psychology irrespective of how they describe themselves. One difficulty with this approach is that many psychological activities are considered the legitimate province of other non-psychology practitioners (e.g., social workers, Indian medicine men, etc.). Nonetheless, licensure continues to be the most desirable form of statutory regulation of health service providers in psychology. The Council of Representatives of the American Psychological Association recently considered a set of proposals recommending changes in the 1967 Model. The net effect of the recommendations would be to restrict the practice of psychology, or the delivery of psychological services, to persons who narrowly qualify as a "psychologist" by virtue of having taken courses labelled psychology offered by accredited psychology departments. A discussion of these proposals in the context of existing guidelines provides the best explication of the current state of licensure and certification. The proposed guidelines offer to change the scope of the existing laws in two respects:

(1) The public use of the title "psychologist" is to be reserved for those who have demonstrated basic competence in psychology through licensure irrespective of compensation. The previous guidelines allowed the use of the title "psychologist" in dealing with the public by unlicensed individuals as long as there were no fees involved.

(2) A second change, of some significance, would derive from an adoption of the proposal to remove institutional and/or governmental exemption. This recommended exemption is a response to court challenges of dual standards

of service for governmental, as compared to non-governmental, treatment facilities (Wyatt v. Stickney, Alabama, 1972) and a recognition that uniform standards of service delivery to consumers is an obligation of the profession. The thrust of this recommendation is to encourage previously exempt institutions to staff themselves with better qualified psychologists so as to provide levels of training and supervision not presently offered. Further, this recommendation makes it explicit that the researcher/academic is not to practice psychology in the public domain as an independent commercial venture without a license.

Contrary to the comments above regarding exclusivity and a narrowing of focus, the proposed guidelines relating to educational requirements for entry into professional practice have been broadened. The language appears to have been made broad enough to insure acceptance of appropriate professional school degrees (e.g., Psyc.D.):

> APPLICANTS FOR LICENSURE SHALL POSSESS A DOCTORAL DEGREE FROM A REGIONALLY ACCREDITED INSTITUTION, PROVIDED THAT THE DEGREE IS OBTAINED FROM AN INTEGRATED PROGRAM OF GRADUATED STUDY IN PSYCHOLOGY AS DEFINED BY THE RULES AND REGULATIONS OF THE LICENSING BOARD.

Terms such as "department of psychology" or "Ph.D." degree have been deliberately excluded from the recommended wording. The recommended language gives Boards the authority to formulate rules and regulations defining professional education in psychology. Only the definition of accreditation is made more explicit.

Finally, the proposed guidelines offer a modification of the definition of psychology:

> THE PRACTICE OF PSYCHOLOGY WITHIN THE MEANING OF THIS ACT IS DEFINED AS, BUT NOT LIMITED TO, THE RENDERING TO INDIVIDUALS, GROUPS, ORGANIZATIONS, INSTITUTIONS, OR TO THE PUBLIC ANY SERVICE INVOLVING THE APPLICATION OF PRINCIPLES, METHODS AND PROCEDURES OF UNDERSTANDING, PREDICTING, AND INFLUENCING BEHAVIOR, SUCH AS PRINCIPLES PERTAINING TO LEARNING, PERCEPTION, MOTIVATION, THINKING, EMOTIONS, MIND-BODY

> RELATIONSHIPS, INTERPERSONAL RELATIONSHIPS, AND INTER-GROUP RELATIONSHIPS SUCH AS METHODS AND PROCEDURES INCLUDING BUT NOT RESTRICTED TO: INTERVIEWING, CONSULTING, THE CONSTRUCTING, AND/OR ADMINISTERING, AND/OR INTERPRETING OF TESTS OF MENTAL ABILITIES, APTITUDES, INTERESTS, OPINIONS, ATTITUDES, EMOTIONS, MOTIVATIONS, PERSONALITY CHARACTERISTICS, AND PSYCHOPHYSIOLOGICAL CHARACTERISTICS: THE ASSESSMENT OR DIAGNOSIS AND TREATMENT OF EMOTIONAL, AND/OR MENTAL, AND/OR NERVOUS DISORDER OR DYSFUNCTION, AND/OR GROUP DYSFUNCTION; PSYCHOTHERAPY; BEHAVIOR MODIFICATION; BEHAVIOR THERAPY; BIO-FEEDBACK TECHNIQUES; HYPNOSIS; MARRIAGE, EDUCATION, AND VOCATIONAL COUNSELING; PERSONNEL SELECTION, COUNSELING, AND MANAGEMENT; EVALUATION, PLANNING, AND CONSULTING FOR EFFECTIVE WORK AND LEARNING SITUATIONS, SOCIAL RELATIONSHIPS, ORGANIZATIONAL DEVELOPMENT, GROUP DYNAMICS; AND THE RESOLUTION OF INTERPERSONAL, INTER-GROUP, AND SOCIAL CONFLICTS.

This definition varies only slightly from the guidelines in the 1967 Model. Proposed changes include the specification of marriage counseling, behavior modification, behavior therapy, and bio-feedback among the listing of covered activities. The justifications given for these additions suggest a concern with an increasing need to specify the activities that qualify as psychology; additionally, the specification prevents other disciplines from exercising sole control over any of these areas.

To summarize, the concern with licensure and certification is responsive to the profession's need to insure that individuals entering into the practice of psychology are well grounded in the core body of knowledge appropriate to such practice. Guidelines and controls are not only designed to promote the best qualified individuals in the profession, they also serve to protect more fully the public interest. In the past there has been a greater reliance on adherence to ethical standards. In other words, individual psychologists engaged in a good deal of self-monitoring in determining whether or not their conduct was in compliance with licensure requirements. Present efforts at modifying licensure requirements are moving in the direction of statutory authority:

> THE BOARD SHALL DEFINE BY REGULATION AREAS AND TECHNIQUES OF PRACTICE IN PSYCHOLOGY FOR WHICH SPECIALIZED TRAINING MAY BE REQUIRED AND SHALL SET STANDARDS FOR SUCH TRAINING. NO PSYCHOLOGIST

LICENSED UNDER THIS ACT MAY ENGAGE IN PRACTICE IN SUCH SPECIALTY AREAS OR MAY APPLY SUCH TECHNIQUES IN INDEPENDENT, UNSUPERVISED PRACTICE UNTIL HE OR SHE HAS MET THE STANDARDS BY THE BOARD.

This approach forces prospective licensees to commit and restrict themselves to the limits of their expertise in their practices. This approach would also decrease flexibility in practice in that individual licensees who wished to change substantially their specialty areas would be required to justify such changes to a Board.

Register of Health Service Providers

As indicated above, most states use the general title of psychology or the general field of psychology in dealing with licensure and certification. The field of psychology, however, encompasses a diverse number of specialties. This wide range of competencies has been the source of both uneasiness and confusion on the part of the public and some agencies. At the request of the Board of Directors of the American Psychological Association, the Council for the National Register of Health Service Providers in Psychology was formed. The Council publishes a Register of psychologists who have voluntarily applied and been identified as health service providers. The Register is made available to governmental agencies on the federal, state and local level, consumer groups, insurance companies, and others involved in health services. This outcome is responsive to the growing need, among private and governmental sources of third-party payments, to identify those psychologists qualified to provide health services. This approach to identifying health service providers is a form of specialty designation based upon general licensing and has the strong endorsement of the American Psychological Association. For these purposes, a health service provider in psychology is a psychologist who is certified/licensed at the independent practice level in his/her state, and is trained and experienced in assessment and in the delivery of preventive and therapeutic intervention services to the public. To date, the National Register of Health Service Providers in Psychology has listed approximately 8,000

psychologists who are qualified to offer health services in psychology. (There are in excess of 25,000 licensed psychologists in the profession.)

A growing concern is that state licensure and certification has fostered a system with variable standards from state to state which may impede the effectiveness and mobility of personnel attempting to deliver health services. Any psychologist who has sought reciprocity coverage as a function of changing residence will readily recognize the problem here. The concern has become focused by some in the professional organizations as a need to establish national standards.

Within psychology two conferences have been convened recently for purposes of discussing training and standardization issues. The Council for the National Register of Health Service Providers in Psychology and the American Association of State Psychology Boards promoted these conferences, although they were hosted and sponsored by the American Psychological Association. An outcome of these conferences was the formulation of a proposed set of definitions regarding the content of graduate programs in psychology, and a proposal for a national commission to evaluate training programs in the context of the proposed definitions. The implication of these proposals for state boards changed with the responsibility of interpreting and evaluating credentials of candidates from a variety of programs would be quite profound.

The proposed revisions to licensure, certification and credentialling have undoubtedly been influenced by the above national themes and currents. Indeed, the proposed revision of the current model was in response to a charge by the APA Council of Representatives to "formulate and recommend policies relative to state legislation matters in order to insure the use of psychology in the public interest."

The response to the proposed guidelines have been both voluminous and volatile. In general, the health service providers or practitioners have been enthusiastic supporters of the proposed model. This group seems firmly committed to the concept of generic licensure "to insure that individuals entering the practice of psychology are grounded in the core body of knowledge in psychology fundamental to such practice." It is the issue of generic credentialing as opposed to specialty credentialing that has proven so controversial. Specialty credentialing would involve licensure only of the fields clinical, counseling, school, and industrial/organizational psychology. The health service providers generally feel that specialty credentialing would lead to chaos and polarization, and perhaps damage the relationship between the profession and state regulatory bodies. Further, psychology would tend to lose its image as an integrated discipline, and possibly split within its own basic subgroupings. According to this view, if all of psychology is grounded in a scientific body of knowledge common to all areas of specialization, fragmentation in licensure and credentialling would surely lead to breakdown and fragmentation in training and other aspects of the profession.

Despite the above arguments, there continues to be strong negative reaction to the proposed model principally from the academic community. A summary of these objections are as follows:

(1) The effort is to license the function of psychologists, rather than certify the title (as is now the case in most states).

(2) The intention is to license <u>all</u> psychologists, not just clinical or those engaged in health service delivery.

(3) The licensing boards--appointed by the governor--would have the power of examination, and the power to determine curricula in graduate programs.

(4) One would have to be licensed to call oneself a psychologist in any context, paid or otherwise, outside the classroom.

The Board of Scientific Affairs of the American Psychological Association considered the proposed model at its recent meeting and voted to express an alarm that reflected concerns already articulated by members of the academic community. The locus of the concern expressed by the Board of Scientific Affairs is that the model makes application to activities and individuals who should not be covered by licensure legislation at all. Specifically:

(1) Research activities conducted outside of academic institutions, such as those carried out by psychologists at NIMH, NIH, VA, independent research laboratories, firms contracting with government agencies, zoos, museums, and state agencies will not be allowed unless the research investigator has a license.

(2) Licensure would be required for academic/research psychologists engaging in activities not part of their academic employment, such as lecturing for a fee, authoring and publishing textbooks, reviewing manuscripts for a fee, consulting with publishers, consulting on research or evaluation projects outside one's academic institution, even though these activities do not involve the delivery of a service to the public.

As one example, the human factors psychologist working in a consulting capacity in industry need not be licensed to preserve the public welfare. It would be unfair to require such a psychologist to submit to a licensing examination designed for practitioners of clinical, counseling, school, and industrial/organizational psychology. A large number of other examples might be given to argue that the activities of many social psychologists, consumer psychologists, engineering psychologists, measurement psychologists, military psychologists, and a variety of other applied psychologists, fall into the

same category. Another way to view the potential range of problems resulting from the proposed model is to examine its impact for an educational psychologist (a not irrelevant consideration for minorities, given that schools of education have been far more attractive to and accepting of ethnic minority individuals):

(1) An academically-based educational psychologist is called in by a state department of education to advise on how best to analyze the data already collected by that department in a statewide evaluation of primary reading and mathematics instruction. The psychologist would need to be licensed.

(2) The English department of a nearby high school asks that same psychologist to come in to explain current psychological theory relevant to school learning and to review from that perspective some planned curriculum revisions. The psychologist would need a license for this too.

(3) Another educational psychologist works for a federally-funded regional educational research and development laboratory. A team of educationists, including the psychologist, are developing for local school districts and training colleges improved teacher training materials and procedures, through a series of field developmental studies, evaluations, and revisions. The psychologist is responsible for designing the evaluation studies and building the student achievement and teacher observation measures to be used therein. This too is licensable under the "Model."

(4) Still another educational psychologist works for a university monitoring the functioning of that university's admissions tests. The psychologist performs psychometric analyses to determine if admissions tests are differentially valid for different segments

of the applicant population and confers with university administrators on the psychometric implications of changes in admissions policy. Again a license is needed.

One can argue that none of these activities should be licensable, or that some indeed should be licensed in the best interests of the public and the profession. If one takes the latter view for at least some of the above examples, then the question arises as to how licensing procedures should be established and controlled. The "Model" addresses generic licensure; while it urges the development of specialty standards, it takes only one step toward accomplishing this. It mandates state boards to define specialties and standards for them. It further suggests that a state board composed of only five psychologist members should typically be sufficient, and it suggests five year terms for each.

An educational psychologist who wishes to engage in activities of the sort exemplified above will thus be required to submit to a general licensing examination designed primarily for clinical, counseling, school, and industrial psychology, and to be judged both generally and in a specialty by a small group of psychologists who are not competent to make such judgments, but whose judgment will nonetheless prevail for years. Licensing boards as defined by the "Model" cannot reasonably be expected to pay significant attention to the problems of licensing educational psychological functions, which are properly regarded by such boards as peripheral to their main health-care related interests. It is noteworthy that the "Model" permits waiver of examination when the applicant holds diplomate status from the American Board of Professional Psychology, but ABPP awards no diploma in educational psychology. The "Model" chooses to certify educational psychologists while ABPP chooses not to!

As can be seen from the above, the consequences of not modifying the proposed model could be adverse to academic/research psychologists who attempted

to do anything outside a classroom setting. The implication is that many would need a license simply to continue doing what they are already doing. However, since the requirements reflect professional service delivery activities, most would have a great deal of difficulty obtaining a license. Can you imagine a distinguished scholar being required to obtain a year of supervised post-doctoral experience to become licensed to continue doing research for which he/she receives honoraria for presenting research colloquia?

Implications for Minority Mental Health Issues

It is difficult to discuss the implications of licensure and certification for ethnic minority/bicultural individuals without a joint consideration of manpower and training issues. The declining minority representation in mental health fields led to the establishment of fellowship training programs for ethnic minority individuals within five professional associations--Psychiatry, Psychology, Sociology, Nursing, and Social Work. As past director of one of these programs, I had an opportunity to get some first-hand insights into mental health needs of minorities and training experiences provided for minorities. The pervasiveness of racism in American culture makes it a number one mental health problem. The obvious victims of this outcome are ethnic minority peoples. A particular irony in this schema of things is that the very racism that contributes to the mental health problems in minority communities, simultaneously prevents or denies minority individuals access to training programs that would provide practitioners to service these communities. This underrepresentation of ethnic minorities in psychology has serious implications for the credibility of psychology as an applied mental health specialty. One such implication is that in most minority communities, mental health needs are being met by alternative approaches. A Human Resources Survey within the American Psychological Association indicates that its minority membership is

most heavily concentrated in the applied areas. This concentration is perhaps the best expression of the fact that individuals who come from a social milieu characterized by oppression and inequitable outcomes seek career outlets that are applied or service oriented. Oppression seems to create a burning desire to engage in the promotion of social amelioration. Not unexpectedly, many of these individuals seek careers as health service providers.

Some indication of the degree of success minorities are experiencing in their quest for careers in mental health professions is revealed in the following statistics:

Psychiatry: A national survey of psychiatrists was conducted in 1970 by the American Psychiatric Association under contract from NIMH. Of 15,543 individuals responding to the race/ethnicity question, 226 (1.5%) were black. A survey of residents in training conducted by the AMA in 1973-74 showed that in that year 82 out of 4930 (1.7%) residents in psychiatry and child psychiatry were black.

Psychology: A survey of psychologists conducted by the American Psychological Association in 1972 showed that of 26,741 members and non-members who answered the question on race/ethnicity, 396 (1.5%) were black. In 1973, of the 4,796 individuals who were awarded doctoral degrees in the social sciences, including psychology, 87 or 1.8% were black.

Social Work: A 1975 survey of members of the National Association of Social Workers found that of 32,706 respondents to a race/ethnicity question, 2,486 (7.6%) were black. Enrollment data show that of 17,388 full time degree students enrolled in the U.S. graduate schools of Social Work in November, 1975, 2,149 (12.4%) were black.

Psychiatric Nursing: While there are no data regarding the racial/ethnic distribution of psychiatric nurses, in the 1970 Census blacks

comprised 7.2% of all employed registered nurses.

The impact of the underrepresentation of blacks is especially felt by their absence in the community mental health centers. Since blacks constitute the largest minority group, extrapolation of these data to other ethnic minority groups would paint a bleaker picture. (That only data for blacks were presented above was simply a matter of convenience). In 1974, the only year in which the Biometry Inventory was coded to receive racial/ethnic designations, it was found that community mental health centers employed fewer minority professional staff than should have been expected given their statistical representation in the available work force. Hence, even beyond the training level, there are forces that prevent ethnic minority health service providers from achieving employment opportunities that would permit them to serve minority populations.

The underrepresentation of ethnic minority individuals in psychology training programs for health service delivery will have at least two outcomes, each of which has implications for licensure. (1) Minority individuals who are denied entry to clinical training programs in departments of psychology will seek comparable training in other departments in related disciplines (e.g., human development, personnel and guidance, etc.). These programs have a reputation and history of being more receptive to ethnic minority individuals than is the case for psychology departments. Consequently, a large number of mental health practitioners who are providing services to minority communities could not qualify for licensure under the proposed regulations since they were not trained in psychology departments. (2) Indigent populations not serviced by traditional health service providers will seek these services from others. While this is true in a number of ethnic minority communities, the medicine man tradition among Indians is the most obvious.

In the Navajo culture practitioners fall into three categories. The herbalist who knows a variety of medicinal plants used for symptomatic relief, the diagnosticians are shamans who work by inspiration, using techniques such as hand trembling, crystal gazing, or star gazing. They divine the nature and cause of illness and make referrals to the singers. The singers, also called ceremonialists or medicine men, are the highest status group. In the Navajo etiology, disease is caused by a disharmony with the universe, including the universe of other men. There is some indication that the Navajo singer knew of the unconscious years before Breuer or Freud published their studies in hysteria. A singer restores this harmony by performing a specially chosen ceremony.

Among the Navajo people a medicine man learns under the apprenticeship of a master therapist. At some point, the apprentice's training is completed at the suggestion of his master. However, the final decision is left to the patients and his ability to find a community that will accept him.

With the advent of community psychology, a larger number of academic disciplines, inside and outside of psychology, have begun to prepare individuals to engage in research and problem-solving in community settings. These activities run the gamut of such issues as juvenile delinquency, problems of the elderly, community control by indigenous populations, drug abuse, mental health, and community planning.

Social engineering has been conceived of as a way of bringing professional help and a commitment to problem solving in communities. It would be an approach that would involve all of the human sciences including psychology. As conveyed in the theme "future shock," our rapidly expanding technology has created innumerable social science/behavioral problems. There is a great need for systematic intervention, by social scientists, into problem-solving

capacities. Social science has been singled out for this mission in large measure because it has the conceptual and knowledge base to deal with social problems of an interpersonal nature.

Housing, poverty and other social problems have had a disproportionate impact on minority communities. In turn, the victims of these experiences have typically demonstrated the strongest motivation to seek social remedies. Community mental health approaches to these problems have resulted in an increasingly larger number of clinical psychologists entering the community arena. The clinical psychologist's rejection of the medical model has put him/her in more direct competition with other specialists in the mental health community. It is quite obvious that many of these non-clinical types have not needed licenses in the past in order to perform these services. A monopoly on licensure and certification for Ph.D. clinical psychologists would unfairly deprive others of gainful employment. This same outcome would result in diminished services to communities. Again, minority individuals and minority communities would disproportionately suffer from this outcome. Medicine men would not qualify for licensure and certification under the proposed requirements; a masters level psychologist or guidance specialist would not qualify for licensure and certification. Although the personnel and guidance specialist could be certified by boards of education, their activities would be limited to the school system. Such individuals could not engage in private practice.

Medicare/Medicaid and Private Insurance

Recent estimates of mental health personnel indicate that there are approximately 27,000 health service providers who are psychologists, and 28,500 physicians who are specializing in psychiatry or neurology. Arguments are being made for including psychologists under Medicare as a way of doubling

the number of health providers and effecting a greater geographical distribution of services to the elderly. Psychologists are already independent providers in other government programs, and many states provide for third-party payments to psychologists under Blue Cross/Blue Shield. Dr. Thomas Bryant, executive director of the President's Commission on Mental Health, has described mental health benefits in Medicare and Medicaid as the "building blocks for a national health insurance."

Congress is presently considering the issue of federally-supported health insurance programs, including mental health. Among the proposals before the Senate is S.123 which was introduced in January, 1977. H.R. 2270, a comparable bill, is pending in the House of Representatives. These bills would provide for the coverage of the independent therapeutic services of psychologists under Medicare. The Senate bill (S.123) will also permit qualifying psychological associations to serve as Professional Standards Review Organizations. These bills are presently co-sponsored by 32 Senators and 106 Representatives--passage is almost assured.

The advantages of third-party payment for indigent individuals is obvious. The implication here, however, is that health service providers who do not qualify for licensure and certification will have a more difficult time maintaining clients whose only ability to pay for services is through a government or private insurance carrier.

In conclusion, it would appear that both existing and proposed licensure and certification guidelines are not in the best interest of minority professionals or communities. Interestingly, along these lines, minority professionals or groups have not been invited to consider these issues. As the title "psychologist" increasingly becomes the sole domain of individuals trained in departments of psychology at the Ph.D. level, an increasingly larger number of minority providers will be excluded. Licensure requirements

further diminish the numbers of individuals trained in academic departments to apply their skills to community problems in all the basic areas of psychology (e.g., developmental, social, physiological, etc.). Many of these individuals are already employed in this capacity. Further requirements for licensure and/or certification seem unwarranted and unnecessary.

* * *

Addendum

Licensure, Certification, and Credentialing...

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The ramifications of Licensure and Certification are many. When these concerns cut across the interests of minority professionals and paraprofessionals the ramifications expand exponentially. With future shock, alienation, increased racism and oppression, the mental health needs of minority communities have increased considerably. The domination and control of the mental health field by physicians have given way to numerous alternative approaches represented by psychologists, social workers, nurses, medicine men, spiritualists, etc. The small number of physicians entering into psychiatry, neurology, or community mental health was not sufficient to meet the growing demand of these communities. Additionally, many third world clients refused to submit themselves to non-third world practitioners, or in some instances non-third world practitioners were incapable of dealing effectively with minority individuals.

Despite the above considerations, physicians continue to dominate the Blue Cross/Blue Shield plans. Since the Blues' insurance system pays 40% of the nation's health bills, only physician practitioners tend to be favored by clients for financial reasons. This is perhaps disproportionately true for third world clients who rely heavily on subsidy for health care services. Needless to say, this outcome interferes with the client's right to freedom of choice of provider, and creates unfair competition for minority/third world practitioners. Further unfair competitive practices are associated with arbitrary

restrictions placed on medical staff membership and associated clinical privileges for non-physician providers • Blue Shield plan boards controlled by physician and/or hospital representatives, and licensure and certification requirements that mitigate against the probability that non-traditionally trained practitioners will be able to serve effectively the needs of third world clients are critical issues.

While this paper will focus on the ramifications of the above issues (and others) for psychologists, it is acknowledged that other disciplines or professions are similarly affected. Implicit in the discussion to follow is an assumption of generalizability of issues to the mental health nurse, psychiatric social worker, spiritualist, Indian medicine man, and many other service providers who receive their training (or calling) from other than accredited departments of psychology. I am hopeful that the workshop participants will contribute to making this generalizability explicit.

Recommendations:

1. Efforts should be made to increase training opportunities for minorities that will lead to larger numbers of individuals qualifying under traditional licensure requirements. Presently five professional associations (psychiatry, psychology, sociology, nursing, and social work) have fellowship programs designed to achieve this goal. These programs are in danger of being phased out after a six-year life. This conference may wish to advocate within the U. S. Congress for an extension of these programs by Congressional mandate.

2. Inasmuch as some minority health service providers will qualify for licensure and certification, it is also important that they qualify for third party payments through Blue Cross/Blue Shield and other plans. Without this access, the public interest of minorities will not be served. Support of House and Senate bills is encouraged as a means of providing insurance coverage for health service providers in professions other than medicine and psychiatry.

3. Increasing emphases on continuing education provide an opportunity to achieve accreditation and certification of nontraditional approaches to health service delivery. While I have no specific recommendation here, I think we should explore ways to achieve "continuing education credits" for experienced nontraditional providers that will lead to qualification for licensing.

4. Ethnic minorities in recent years have generally formed separate professional associations (e.g. La Raza, Association of Black Psychologists, etc.). For the most part, these groups have operated outside of, and independent of, the major associations for these professions. There are, at least, two problems associated with these strategies: a) Minority individuals are excluded from involvement with the professional associations that determine and influence the course of accreditation and licensing. b) Minority associations are denied access to the political and economic leverage of the major professional associations. I would recommend that we pursue individual and institutional membership (divisional status) as a means of putting ourselves in the informational flow, and as a strategy to utilize larger institutional resources in accomplishing our purposes.

5. Congressional appropriations for mental health are largely administered through HEW and ADAMHA. It is presently proposed that the Minority Center be elevated to divisional status. Since the Minority Center is currently providing the largest single measure of support for minority training and research in mental health, independent divisional status would tremendously advantage the minority professional community. This conference should go on record as supporting divisional status for the Minority Center. Further, we should encourage the Minority Center to support investigations into nontraditional styles and approaches to health service delivery.